

Hospitals and the Public Interest

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IN 1958 the insurance commissioner of Pennsylvania issued a now-famous adjudication on the application of the Philadelphia Blue Cross plan for a premium increase (1). In explaining his refusal to grant the increase, the commissioner offered a bill of particulars on the operation of both Blue Cross plans and hospitals, suggesting widespread neglect in the control of hospital utilization and costs. In the following months, official investigations were launched in several States on the whole question of hospital management and economics.

The first reaction to these signs of strong governmental intervention into hospital affairs was one of surprise and indignation. What right did an insurance commissioner have to suggest that either a Blue Cross plan or a governmental agency should pry into the operation of institutions that were predominantly under local voluntary auspices? Charges were made of "attacks on the voluntary hospital system" and creeping socialism. At about the same time, Cornell University was called on by the State of New York to help prepare new legal standards for the approval of general hospitals, and we were likewise attacked as accomplices in the crime of governmental interference with free hospital enterprise (2).

As the dust has settled, it has become clearer to many that hospitals in the United States are, indeed, subject to various forms of supervision by public agencies. Yet many look at the trends with anxiety. It may help to clarify the changing hospital world if we examine the

basis of public interest in hospitals, the voluntary safeguards of this interest, the role of government, and new issues of public concern. Then we may be able to look ahead to future needs for reasonable supervision of hospitals in the American scene.

Basis of the Public Interest

What is the basis of the public interest in hospitals? Fundamentally, it lies in the obligation of the community to protect the health of its members. This responsibility is dispatched through both voluntary and governmental actions. Through a long tradition of political experience and legal precedent, some (though not all) of this theoretical obligation of government is embodied in constitutions. The U.S. Constitution may not spell out "hospitals" or even "health" as subjects of governmental concern, but the "general welfare" clause has been interpreted again and again to include within it the power to safeguard the public health. Except for foreign or interstate activities, however, power in health affairs rests essentially with the State governments. The New York State constitution, for example, states that "the promotion and protection of the health of the inhabitants of the State are matters of public concern."

The States are amply endowed legally to support this public concern. They possess what is called juridically "police power," permitting State governments to protect the health, welfare, safety, and morals of their citizens. The rational foundation of this power may be the need to protect individuals from the harmful acts of others or even from personal imprudence. Hence the State exercises its police power over the sale of drugs or the wages and hours of working people. It may require vaccination against smallpox and quarantine of per-

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sons with diphtheria. Likewise it may regulate hospitals since these institutions may intimately affect the life and well-being of the people.

Beyond these philosophical and legal foundations for a public interest in their operation, hospitals derive from the State certain special privileges. At the same time, the State imposes certain obligations on them.

Generally hospitals are incorporated bodies, chartered by the State like other corporations. Directors are substantially relieved of individual responsibility for the wrongdoing of the corporation; instead, the legally created corporate "person" is responsible and liable only to the extent of its collective assets. Considering the possibilities of negligence, harmful acts, and malpractice suits in a hospital, this limited liability is obviously of great importance. As corporations, hospitals have the capacity for perpetual existence, without the necessity of complex transfers of title on the death of individual founders. The responsibilities of corporations are defined by law and are subject to a charter granted usually by the secretary of state in each State (3).

Because of their usually charitable and non-profit character, except for the handful of proprietary institutions, hospitals enjoy tax exemptions of many sorts. They are exempt from Federal income taxes and from many excise taxes levied on other enterprises. They are also exempt from local property taxes, and often from local sales taxes on their purchases. Moreover, hospitals may receive gifts from donors who thereby enjoy reductions of their net incomes for tax purposes; hospitals thus receive funds which would otherwise be payable in large part to the government as private income taxes.

Hospitals may receive substantial grants of public money for construction purposes. The extent, of course, differs with the hospital's sponsorship. About one-third of the hospitals in the United States are fully owned by units of government, predominantly State and local, and were built entirely with governmental tax funds. Even excluding special hospitals for tuberculosis and mental disorder, Federal facilities for veterans or merchant seamen, and all long-term facilities, and counting only

short-term general hospitals serving local communities, there are more than 1,100 such institutions which have been built substantially from public funds. Beyond this, voluntary hospitals have long received governmental construction grants. Such support has been given since the earliest days of the Republic, when the Pennsylvania Hospital in Philadelphia and the Massachusetts General Hospital in Boston received grants from State legislatures and municipal governments. State governments have in more recent years given such grants to help hospitals in rural communities. Since 1946, of course, the Hill-Burton program has provided substantial Federal money to assist voluntary and public hospital construction on a nationwide scale. Such contributions of public funds have entailed public responsibility for overseeing how the money is spent on the physical plant.

Governmental units purchase services from hospitals on behalf of certain legal beneficiaries. The largest share of these are indigent persons receiving public assistance from State or local governments; that is, recipients of categorical or general assistance. In addition, many States assume responsibility for hospital services to selected persons who are "medically indigent"; that is, unable to pay hospital bills although not on the relief rolls for their general living needs. The new Federal law on medical care for the aged, enacted in September 1960, may enlarge this group considerably. Then there are a variety of other beneficiaries of governmental programs, such as those for workmen's compensation, vocational rehabilitation, or crippled children, who are ordinarily treated in community hospitals. Finally, there are beneficiaries of the Federal Government, ordinarily served in special Federal hospitals, who may receive care in local general hospitals on occasion; these include veterans, uniformed service dependents (the "medicare" program), American Indians, and others. The content of care given to all these beneficiaries is a matter of public concern. In some States, indeed, it is the principal legal foundation for the whole licensure program, with responsibility being assigned to the welfare department because of its authority for overseeing care to the indigent.

Another foundation of public interest in

hospitals is their provision of a locale for the work of several licensed health professions. Physicians, nurses, physical therapists, technicians, and others who work in hospitals individually derive their rights to practice from special examinations and licensing procedures. But the very concentration of these personnel under one roof would seem to place a special responsibility on government regarding the technical standards of the environment under that roof. Surveillance over the management of affairs of hospitals provides a channel for some continued assurance of proper performance by these professions, after the initial licensure.

The hospital is also an educational institution, most conspicuously for nurses but also for other occupations. Laboratory technicians, rehabilitation therapists, social workers, dietitians, and pharmacists may receive substantial parts of their basic training in hospitals. Physicians are educated in hospitals throughout their professional lives, not to mention their periods of service as interns and residents and their training years as medical students. Insofar as supervision of education is widely considered a public responsibility in our society, the hospital is partly a school requiring such supervision.

The hospital, furthermore, is an employer of men and women, subject accordingly to the laws of the land controlling the conditions of labor. Exemptions may be made regarding certain wage, hour, and collective-bargaining provisions because of the hospital's usually nonprofit character, but such exemptions are a matter of legislative decision rather than constitutional right. The exemptions could be withdrawn and, as we shall note, there are legislative winds blowing this way. In any event, conditions of work in hospitals are obviously matters of public interest, with about 1,500,000 persons employed in them on a full-time basis.

Finally, there is the question of hospital operating costs, which have obvious importance for the general public. In recent years, public concern about this has become an overriding issue. Not only has there been widespread popular reaction to the sharp rises in hospital costs, but the channel of expression of this re-

action has been widened through a separate but closely related social movement: hospital insurance. The Blue Cross plans inevitably reflect hospital costs in their premium charges to subscribers. Being insurance organizations, though nonprofit, they come under the supervision of State insurance commissioners, and these officials must be responsive to public attitudes. Thus, the insurance financing of a major share of hospital costs in recent years—in other words, support by the mass of people rather than solely the sick—has heightened public interest in hospital costs. Obviously, the people have a right to know how their insurance money is being used by hospitals; if there is inefficiency or extravagance, they have a proper concern in eliminating it.

These, then, are the principal reasons for a public interest in hospitals. Perhaps it epitomizes the situation to say that hospitals are essentially public utilities. They are so important to the survival of the community that they have been granted many special immunities and statutory rights. At the same time, their actions may lead to good or poor consequences for the people. For both reasons, citizens and organizations outside the walls of the hospital have assumed a variety of responsibilities for looking in on them and exerting various pressures to assure proper performance.

Voluntary Safeguards

Consciousness of public interest is responsible, at least in part, for the conventional pattern of a board of directors as the top authority of each general hospital. The hospital board is theoretically a kind of built-in protector of the public interest. Its roster is supposed to include persons who represent the community: if not popularly elected, then appointed on the basis of their position as leaders able to judge the interests of the population as a whole.

In practice, we know that the democratic ideal is rarely attained anywhere. Hospital boards may be composed of highly intelligent and responsible persons, but they come predominantly from business and professional groups (4). Their sensitivity to the needs of humble people may be limited, and their willingness to take particular actions may be strongly influenced by their personal views,

which may or may not coincide with maximum protection of the public interest. Moreover, they are often persons who have given substantial donations to the cost of building the institution; hence, they will feel proud and possessive toward it, protecting it against criticism. An attitude of "my hospital, right or wrong" may assure loyalty but not necessarily optimal performance for the general good. These observations should not deprecate the devotion and diligence of most hospital board members, but they do cast doubt on the reliability of the board mechanism for protecting the public interest.

Yet every decision that a hospital board or its administrator makes is laden with public interest. The hospital's handling of funds, its maintenance of the physical plant, its appointment of personnel, its provision of technical services, its policies, its staff organization—all affect the adequacy of care given by physicians and others. Not that every decision should be subject to review by a higher authority, but the overall effect of these decisions—or failures to make decisions—is manifestly of great public concern.

There are other boards of citizens at the local level that may examine aspects of hospital operation from time to time. Community chests or councils may look into how funds they have granted are spent. Blue Cross boards may indirectly call for economies. Governmental agencies buying services for various beneficiaries may demand that certain standards be met. But the focus of each of these groups tends to be narrow and their impact is limited.

To provide more general surveillance over hospitals, a number of national nongovernmental associations have taken action. The first such body of wide impact was the American College of Surgeons which, shortly after World War I, developed a nationwide system for approval of hospitals meeting certain standards of organization and practice. Meanwhile the American Hospital Association established limited standards for membership and "listing" in its annual roster. The American Medical Association, through its Council on Education and Hospitals, developed a system of approval of hospitals for internships, residencies, and postgraduate education. Special

approvals for such services as tumor clinics, blood banks, and schools for X-ray and laboratory technicians were given by other professional societies or voluntary agencies.

These specialized approvals, on the whole, continue, but in 1952 there was organized an overall system of hospital "accreditation" by a joint commission made up of representatives of the American College of Physicians, American College of Surgeons, American Hospital Association, American Medical Association, and the Canadian Medical Association. This commission undertakes inspections throughout the Nation and has doubtless had a major effect in upgrading hospital performance. The prestige of accreditation has come to be regarded as an essential asset in a hospital's public relations. Withdrawal or the threat of withdrawal of accreditation provides a strong incentive to improve practices. In contrast to the State government licensure systems, the main emphasis of the joint commission's work is on medical staff practices, although a comprehensive review is made.

Despite the notable achievements of these voluntary bodies, their shortcomings must be recognized (5).

- They are voluntary and no hospital need even apply for their approval; indeed, some of the marginal institutions, in greatest need of improvement, avoid the whole process. Even if an institution seeks approval and fails to get it, there is no penalty except nonapproval. In a one-hospital community, without "competition" for patients, this moral penalty may have little effect.

- The Joint Commission on Accreditation makes a policy of examining only hospitals of 25 beds or more. Yet 800 hospitals in the United States are smaller than this, and these institutions may present the thorniest problems. The Georgia Hospital Association and the Georgia Department of Public Health have been unusual in launching a special accreditation program for these small units.

- These professional societies and commissions are, of course, independent and responsible only to themselves.

While their integrity may be beyond question, they do not unflinchingly reflect the public interest. Their viewpoint, indeed, is sometimes

parochial; they avoid inspection and accreditation of osteopathic hospitals, for example, despite the fact that these institutions give care to thousands of patients. In the recent contentions between radiologists and hospitals about schemes of organization, these professional societies have stood aloof, not lending their weight toward whatever side they judge to be in the public interest.

In the light of these shortcomings in voluntary mechanisms for protection of the public interest in hospital operations, and in spite of their enormous positive achievements, there remains in a democratic society an overriding need for public supervision of hospitals. Only through governmental authorities, responsible ultimately to the whole people, can this supervision be fully and effectively exercised. The responsibility of government is carried out through the political process. This process in turn, has been increasingly fortified by merit systems for appointment of officials, especially in technical fields. Government agencies may solicit and receive expert advice from many sources, but the final policy decisions must rest with the agencies. They are ultimately accountable to the citizenry, who can vote the top policymakers out of office if dissatisfied. Governments have, in summary, not only the power but also the obligation to protect the public interest.

Role of Government

The principal means by which governmental agencies have come to protect the public interest in the operation of hospitals is through licensing by State authorities. The laws defining this power are relatively new. Before 1945, only 10 States had any form of hospital licensure law, the exercise of public surveillance being confined principally to the State licensure of physicians and other health personnel working in hospitals. The Federal Hospital Survey and Construction Act of 1946, however, was enacted in a period when consciousness of the public interest in hospitals had matured. It contained therefore a stipulation that every State receiving Federal grants for aiding in hospital construction should have a law governing minimum standards of maintenance and operation for at least the subsidized facilities.

In time, every State passed such a law, and in all but two States, Delaware and Louisiana, it has come to be applied to all hospitals in the State (6).

In these State laws, the legislature usually declares that every hospital must have a license granted by a particular State agency, typically the health department. The health department is authorized to issue regulations to carry out the legislative intent, which is usually broadly defined. The Missouri statute, for example, declares it to be the legislative purpose to "provide for the development, establishment, and enforcement of standards (1) for the care and treatment of individuals in hospitals and (2) for the construction, maintenance, and operation of hospitals, which, in the light of advancing knowledge, will promote safe and adequate treatment of such individuals in hospitals," and authorizes the Missouri Department of Public Health and Welfare to adopt, amend, promulgate, and enforce rules to accomplish the purposes of the law (7).

The adoption of such a statute represents a forceful exercise of the police power of the State. It grants to the public authority the power to determine the precise conditions under which a hospital shall be operated. If anyone sets out to operate a hospital without meeting these standards, he is subject to prosecution. While these powers are seldom invoked, their existence strengthens the effectiveness of suggestions for improvements made by State agencies.

With such sweeping powers at their disposal, State agencies are faced with many delicate questions about the scope and content of regulations that they adopt. To what precise aspects of hospital operation should the regulations apply? How detailed and specific should they be? Should the regulations tolerate mediocre or second-best practices, so long as they are not proved to be harmful, or should they set more rigorous requirements? Should there be a "grandfather clause" in hospital regulations, permitting more lenient standards for old institutions than for new ones? Should different standards be accepted for large hospitals and small ones, merely because of their size or because of their differing roles in a regional network? In all these questions, the technical con-

siderations must be blended with political judgments. Government officials must decide how far public understanding will support their actions.

The older State hospital regulations tended to construe their authority narrowly. Their attention was concentrated on protection of the safety of patients; they were explicit about details of the physical plant, including such items as fireproof construction, number and location of exits, the maintenance of buildings, and so on. Details of water supply and sewage disposal were also spelled out, in the older public health tradition. Public concern for mothers and babies has also been expressed in special requirements for hospital maternity departments.

The newer State hospital regulations are concerned with much broader aspects of hospital organization. There are requirements on the functions of a governing board and administrator, on the medical staff organization (by-laws, selection of physicians, restrictions, and so on), on detailed clinical records, on the laboratory and X-ray departments, on the nursing service, dietary management, and so on. A few State agencies have ventured into the ticklish problem of requiring admission-discharge control committees. There are also, of course, requirements on physical plant and sanitation. In short, the scope of the hospital licensure regulations in most States today is broad enough to determine whether the hospital is built, organized, equipped, and staffed in a manner adequate to do the job expected in modern society (8).

The writing, interpretation, and enforcement of hospital licensure regulations, however, are not simple matters. To strike a compromise between the ideal and the practical, it is common for licensure codes to set out certain standards as mandatory while others are simply "recommended." The mere official publication and discussion of the recommended standards serve to encourage higher levels of hospital performance. From time to time a recommended standard will be changed to a mandatory one, so as to promote improvement of hospitals at a realistic pace.

Quite apart from a deliberate objective of the State licensure agency to encourage im-

provements, standards must be reviewed continually to be certain that they reflect changes in scientific knowledge. Some 10 years ago, for instance, hospital standards stressed the need for ample oxygen for premature infants. The discovery of the danger of producing blindness, retrolental fibroplasia, by providing too much oxygen to premature babies required a quick shift in the licensure standard. The emphasis is now placed on controls to assure a precise concentration of oxygen.

Some might ask, however, whether the licensure standard should not be stated in terms general enough to eliminate the need for frequent amendment. Would it not be easier, for example, to have regulations simply state: "Where premature infants are cared for, a supply of oxygen appropriate to their needs shall be provided"?

The doctrine of generality in licensing regulations unfortunately is deficient on both legal and practical grounds (9). Primarily, a regulation with the force of law must be specific and clear enough to enable the person or organization being regulated to know what he must do to comply and what he must not do to avoid violation of the law. What guidance is offered to Oklahoma hospitals, for example, by the State regulation that "sufficient registered nurses shall be employed to assure adequate care of patients"? Even if our stage of knowledge does not permit absolute standards on many subjects, certain bare minimum levels may be stipulated. A requirement that "at least one registered nurse for each 20 (or 40 or 50) patients shall be provided by the hospital" can be understood and can be helpful.

The importance of specificity in hospital regulations is heightened by the realities of law enforcement in this field. Even the best manned State hospital supervising agency, with the most competent staff, could not inspect hospitals frequently enough to assure absolute compliance with the regulations. In a field of service with the high moral purpose of hospitals, moreover, such policing would be repugnant and unnecessary. The issuance of the regulations is ordinarily enough to induce compliance, but only if the standards are clearly stated. If they are open to varying interpretations, not even the best hospital can be certain

how to comply, while the poorest may take refuge in their vagueness.

A troublesome aspect of hospital regulation arises from the frequent multiplicity of regulatory agencies in a State and from inconsistencies in the rules issued by each of them. In New York, for instance, general hospital regulations are issued by the State board of social welfare. Specific rules, however, on newborn nurseries, vital statistics, communicable diseases, laboratory and radiology departments, and the handling of cadavers are issued by the State health department for hospitals outside New York City; still other rules on these subjects for hospitals in New York City are issued by the city health department. Educational programs in hospitals are regulated by the State board of regents. State and local fire regulations, multiple dwelling laws, and zoning ordinances affect hospitals through still other jurisdictions.

There are complex historical reasons for this dispersal of authorities for hospital supervision in State governments, not to mention delegations of certain authorities to local governmental units. The intricacies of government are exasperating not only to the population at large but to public officials themselves. Reorganization commissions at the Federal and State levels have attempted to streamline public administration for years, and the task is never ending. There are some, of course, who emphasize the benefits of dispersed governmental authorities as a protection against political czarism. At the same time, in the hospital and health field splintered authorities tend to weaken the effectiveness with which public agencies can protect the public interest.

There are other reasons, however, why many State hospital licensure programs are less effective in practice than they would appear by studying the language of the written regulations. The responsible agency tends to be meagerly financed and staffed. The qualifications of licensure personnel are often modest. Most States seem to rely heavily on registered nurses, whose competence outside the field of nursing care is often limited. At bottom, perhaps, there is a certain hesitation on the part of State governments to pry too closely into the affairs of voluntary institutions associated with

so distinguished and ethical a tradition as that of the medical profession and the community hospital.

But the public interest in hospitals, as we have noted, remains wide and is growing wider. The need for effective programs of governmental supervision of hospitals is more pressing than ever, not only because of the greater demands of the public for the highest technical performance in matters of life and death, but because of a number of issues that have become especially prominent in the last few years.

New Issues of Public Concern

Back of the problem of sharply rising hospital costs, mentioned at the outset, are a series of questions demanding action on a broad community basis. The widespread financing of hospital care through insurance has extended the interest in these questions from individual hospital boards to the population as a whole.

One of these new questions concerns the whole level of hospital utilization in a population that is heavily insured. Are hospitals being overused by some patients and some doctors so that the costs rise for everyone? This is a complex question on which there has been a good deal of confused thinking. If there is any improper use of expensive hospital beds, one must be cautious about accusations, since such usage always involves the concurrence of three parties—the patient, the physician, and the hospital. The forces acting on each are manifold (10). An approach to the problem calls for discipline by physicians on hospital staffs; their judgment on the use of a given bed is decisive. Is there not a place in hospital regulations therefore for some procedure, such as a designated medical staff committee, to assure the proper admission and discharge of patients, so that costly hospital beds are soundly utilized? (The establishment of such a committee in every Blue Cross participating hospital was, in fact, required by the 1958 decision of the Pennsylvania insurance commissioner.)

Closely related to the use of hospital beds is the issue of their supply and location. Strangely enough, no State now exercises control over this basic question. The licensure laws specify that a hospital to be constructed

must meet certain standards, and if these standards are met, the hospital must be licensed. The State agency may not examine whether the additional hospital beds are needed, except for the minority, about one-fourth, of hospitals receiving Federal construction funds. Yet studies in the United States and elsewhere have shown that the most fundamental determinant of the expenditures of a Nation or a State for hospital service is the supply of beds provided. The beds that are there tend to be used (11).

We are not suggesting that too many hospital beds are available and that further construction should be stopped. Far from it; in fact, we believe that a proper meeting of health needs probably demands a higher ratio of beds to population than we now have, especially of beds for the aged. But we are suggesting that any effective public control over expenditures for hospital service by the population as a whole requires a conscious and deliberate control over the supply of beds in a State. This policy has been recommended by some in terms of a "franchise" to be issued by a public agency for hospital construction or extension (12). Others have called for issuance of approval for all new hospital construction by regional councils set up under State law (13). However it may be done, the need for some type of governmental control over the supply and location of hospital beds in a State seems to be increasingly accepted.

A third current issue relates to the policies of hospitals on appointment of physicians to their medical staffs. It is well-settled doctrine that the governing board of a voluntary hospital has the authority to permit or deny physicians the right to practice in the institution. There are sound technical reasons for hospital boards to limit the privileges of attending physicians by barring them completely or by defining more narrowly than the State medical licensure laws what they may do within the institution. At the same time the U.S. Supreme Court and other courts have held it illegal, under the antitrust laws, for medical societies to exert pressure on hospital boards to exclude physicians from hospital staff appointments because of their economic patterns of practice. This issue has arisen several times with respect to denial of hospital privileges

to technically qualified physicians engaged in prepaid group medical practice—most recently in Staten Island, N.Y. (14,15). Is there not an important question of public policy involved, insofar as the patients of these doctors may need hospital care and the patients are, indeed, contributing to the support of the hospital through insurance payments? Should not a public agency be prepared to protect the public interest in an issue of this sort?

A fourth issue relates to the use of drugs in hospitals. Recent investigations by a U.S. Senate subcommittee into the prices of brand-name drugs have led to a renewed interest in the application of formularies calling for the use of generic-name drugs wherever feasible. Yet, in Pennsylvania, a hospital pharmacist was penalized for filling a prescription with a generic-name form of a drug rather than with the brand-name form of the same drug, as prescribed by a physician. His hospital's official formulary stipulated use of the generic form (16). The right—or perhaps even the obligation—of hospitals to use drug formularies would seem to be a matter of clear public interest that ought to come within the purview of State licensure regulation.

A fifth issue concerns labor standards. Although employees of voluntary hospitals do not have the protection of the Federal wage-and-hour standards, they may be covered under the State laws. In 1960, the minimum wage law of New York State, for example, was amended to cover the employees of nonprofit corporations, including hospitals. Unless specific exemptions are ordered by the State industrial commissioner, these employees will shortly be paid a minimum wage of \$1 an hour. In a number of States, furthermore, the right of collective bargaining through hospital unions is protected by law and may be enforced by State labor agencies (17). The public interest in these fields has been justified on two grounds: first, to assure decent wages for all persons working in the State; and second, to assist hospitals in maintaining a qualified and stable working force in a competitive labor market.

There are doubtless other issues in today's hospital cauldron, but these may be enough to explain the heightened relevance of hospital affairs to the general public interest. All of

these questions affect the costs of hospital care, which almost everyone must now finance. They likewise affect the quality of hospital care, which ultimately influences the life or death of patients. There are, indeed, a wide range of professional measures which may be taken to encourage top-quality performance—tissue committees, medical audits, postgraduate education—in certain hospitals. While the administrative task might be complex, would it not be appropriate protection of the public interest to require such measures to be undertaken in all hospitals?

Future Needs

Perhaps to some this sounds like advocacy of an unreasonable extension of governmental authority over voluntary hospital affairs. We can only say that the issues have arisen not from any hunger for authority by public officials, but rather from the experiences and reactions of the general public. Hospitals are becoming more and more important to people, both for their services and their costs. And their conduct acquires therefore the attributes of a public utility, which cannot be left solely to the prerogatives of its managers but requires the increasing surveillance of a public authority. While voluntary discipline can and does reduce the need for governmental controls, an ultimate need for them remains.

Others may regard the delegation of such wide authority to government as unrealistic. What State agency, they may ask, can command the skills necessary to provide the wide scope of supervision called for? Admittedly, there is no State agency now equipped to do the job. It is small wonder that, with their present meager staffs, the State hospital licensure agencies have so often concentrated their attention on the details of physical plant and safety inspection. It is small wonder that, in their present role, hospital licensure authorities have been regarded rather casually by hospital administrators, and the impact of these authorities has been felt to be slight (18).

A properly staffed and authorized State agency for hospital supervision, however, could be equal to the responsibilities which the times demand. A beginning has certainly been made in a few States which have taken seriously the

language of their licensure codes (19). In one of the Canadian Provinces with a program of hospital insurance encompassing its entire population of about 900,000, there is a division of hospital administration and standards with 23 professional personnel. These include a medical director and consultants in general hospital administration, nursing, dietetics, pharmacy, radiography, laboratory technology, social work, problems of physical plant, accounting, auditing, and health education. In addition there are part-time consultant services provided by other departmental personnel in sanitary engineering, architecture, medical records, and statistics. Records of the Saskatchewan Department of Public Health, Regina, Canada, show that the cost of maintaining this supervisory staff, in relation to the costs of the hospital service itself, is only a drop in the bucket.

In 1957, the American Hospital Association undertook a study to determine an appropriate range and qualifications of staff for State agencies responsible for supervising hospitals. The results do not seem to have been published, but preliminary documents suggested a need for much more comprehensive staffing than prevails anywhere (personal communication from Hilary Fry, January 15, 1958). Not that such staffing would imply a corps of rugged inspectors to crack the whip over hospital administrators. On the contrary, the goal of a State hospital licensure agency must be to upgrade performance and encourage excellence—not to punish or intimidate. To do this, official personnel must play the role essentially of consultants, advising hospitals on how to meet, or surpass, the legal standards and how to continually improve their services within a framework of maximum economy. There is no reason, incidentally, why much of the advice, now purchased at high fees from private hospital counseling firms, could not be given freely by a really sophisticated staff of technical consultants in a governmental agency. This is the custom in Canada and Europe.

To back up the actions of the hospital licensure staff—or perhaps we should call it the supervisory and consultant staff—the official regulations should come to grips with the significant problems of hospital operation in the

20th century. Here is a list of the 17 chapters in a proposed set of hospital standards which our institute recently drafted at the request of the New York State Department of Social Welfare:

Administrative organization and services.	Outpatient and preventive services.
Admission and discharge of patients.	Pharmaceutical service.
General clinical services.	Medical social service.
Anesthesia and inhalation therapy.	Medical records and library.
Laboratory services.	Educational activities.
Physical medicine and rehabilitation.	Dietary services.
Dental service.	Sanitary functions.
Nursing service and patient accommodation.	Physical plant.
	Special hazard problems.

Regulations of this breadth should not be drawn up unilaterally by a State agency. They should be drafted in consultation with representatives of the hospitals. They should obviously be revised at frequent intervals. Their application by the staff, moreover, should be strengthened by the support of an advisory council representing the hospitals, the health professions, and the general public. An important step in the direction of strengthening the overall State programs of hospital licensure was taken by the formulation of "recommended principles" in this field by the American Hospital Association in May 1960 (20).

With proper legal standards and with staffing to apply them, the farflung public interest in hospitals could be adequately protected. Many of the problems that now beset hospital boards and administrators could be reduced. The public would be set at ease in its suspicions about waste or inefficiency in hospital management. The patient would be reassured about the quality of service, not just in those institutions that are manifestly excellent, but in all institutions. The rights of the community to have the best quality hospital service at the lowest feasible cost would be steadily advanced.

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